MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09795

Reg. Dist. No. 351

WITHIN CORPORATE LIMITS OF

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: Arthur D. Blake

3.(b) Social Security Number: 215-16-8163

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 22 - 1897 (?)

8. AGE: Years: 51 | Months: 0 | Days: 28 | If less than one day: hrs. min.

9. Birthplace: Snow Hill Worcester, Md. (Town, county, and state)
10. Usual occupation: Tailor
11. Industry or business: Saw-Mill

FATHER
12. Name: Noah Blake
13. Birthplace: Maryland

MOTHER
14. Maiden name: Robinson
15. Birthplace: "

16. Informant: Mr. Oscar F. Blake
Address: Snow Hill, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 22/48 (month) (day) (year)
Cemetery or crematory: Baptist
Location: Snow Hill, Md.
18. Funeral director: Clay E. Timmons
Address: Snow Hill, Md.
19. 9/24 1948 (Date rec'd by registrar) R. Clay Smith, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 20 1948 at 7 3/4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1945 to Sept 20 1948 and that I last saw h[illegible] alive on Sept 20 1948

Immediate cause of death	DURATION
Rupture of the aorta	1 hr.
Due to Inoperable squamous cell Carcinoma of the Esophagus	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Inoperable squamous cell Carcinoma of the Esophagus Date of op. May 1948
Autopsy? At Ft. Hayes Veterans Hospital
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert L. LeMar, M.D. M.D. or other
Address: Snow Hill Date signed: 9-22-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09796

CERTIFICATE OF DEATH 92a

Reg. Diat. No. 355

1. PLACE OF DEATH:

County Worcester

City or town Berlin R F D

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Worcester

City or town Berlin R F D

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME KATE GIBBS HALL

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife Nathan C. Hall.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 17, 1877

8. AGE:	Years	Months	Days	If less than one day
	71	3	1	..... hrs. ..... min.

9. Birthplace Berlin Wor Co. Md. (Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business

FATHER — 12. Name John D. Gibbs.

FATHER — 13. Birthplace Berlin Md.

MOTHER — 14. Maiden name Sally Parnell.

MOTHER — 15. Birthplace Md.

16. Informant Mrs. Howard Hall.

Address Berlin Md. R F D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/20/48 (month) (day) (year)

Cemetery or crematory Evergreen.

Location Berlin Md

18. Funeral director Bunce A Burbage

Address Berlin Md

19. 9-20- 1948 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1948 at 8:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1947 to Sept 1948

and that I last saw her alive on Sept 17 1948

Immediate cause of death Aortic Stenosis — DURATION 5 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Nathaniel F. Thomas M.D. M. D. or other

Address Ocean City, Md. Date signed 19 Sept 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct as is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a 09797

Reg. Dist. No. 351

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 87 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Edna a. Henman

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Thomas J. Henman
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Dec 25 – 1860
8. AGE: Years: 87 Months: 8 Days: 21 If less than one day: hrs. min.
9. Birthplace (Town, county, and state): Snow Hill Worcester Md
10. Usual occupation: Housewife
11. Industry or business: Own home
FATHER 12. Name: John Cutts
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Annie Johnson
MOTHER 15. Birthplace: Maryland
16. Informant: Miss Minnie E. Henman
Address: Snow Hill, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 19 48 (month) (day) (year)
Cemetery or crematory: What Cheer
Location: Snow Hill, Md
18. Funeral director: Clay E. Dennis
Address: Snow Hill Md
19. 9/18 48 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 16 1948, at 12 45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1948 to Sept 16 1948 and that I last saw her alive on Sept 15 1948

	DURATION
Immediate cause of death: Acute Pulmonary Edema	2 days
Due to: Chronic Congestive Cardiac failure	3 yrs
Due to: Degenerative Cardiovascular Renal disease	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert L. La Mar, M.D. M. D. or other
Address: Snow Hill Date signed 9-17-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A16 9-45-15M

09798

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 350

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County Worcester
City or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Rural Pocomoke Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war World War 1

3. (a) FULL NAME John S. Jones

3. (b) Social Security Number —

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Viola Mae Jones
6.(c) If alive, give age 48 years
7. Birth date of deceased (mo., day, yr.) January 20 - 1896
8. AGE: Years 52 Months 7 Days 17 If less than one day ...hrs. ...min.
9. Birthplace Pocomoke Worcester Md. (Town, county, and state)
10. Usual occupation Farming
11. Industry or business
FATHER 12. Name Marion F. Jones
13. Birthplace Md.
MOTHER 14. Maiden name Vemma Redden
15. Birthplace Md.
16. Informant Mrs Viola Mae Jones
Address Rural Pocomoke Md.
17. Burial Date thereof Sept. 10-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Baptist Cemetery
Location Pocomoke Md.
18. Funeral director Henry K. Watson
Address Pocomoke Md.
19. Sept. 10, 1948 Anne E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 1948, at 10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h~~im~~ ~~alive~~ dead Sept 7th 1948
Immediate cause of death Coronary disease — DURATION UK
Due to
Due to
Other conditions Parked his truck + died instantly at wheel
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Deputy Med Examiner [signature] M.D. or other
Address Pocomoke City Md. Date signed 9/8/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09799

166

CERTIFICATE OF DEATH

Reg. Diat. No. 355

1. PLACE OF DEATH:

County: Worcester

City or town: Bishopsville, Md. RR

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Worcester

City or town: Bishopsville Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Mumford

3.(b) Social Security Number 221-16-5042

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1924

8. AGE: Years: 23 | Months: 10 | Days: 5 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Bishopsville, Md. (Town, county, and state)

10. Usual occupation: Day Laborer

11. Industry or business

FATHER — 12. Name: Henry Mumford

FATHER — 13. Birthplace: Synepuxent, Md.

MOTHER — 14. Maiden name: Nellie Walters

MOTHER — 15. Birthplace: Bishopville, Md.

16. Informant: Henry Mumford

Address: Bishopville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-8-1948 (month) (day) (year)

Cemetery or crematory: Evergreen Cemetery

Location: Berlin Md.

18. Funeral director: Henry W. Watson

Address: Pocomoke City, Md.

19. 9-8- 1948 (Date rec'd by registrar) Helen B. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 4th 1948, at 8 1/2 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19..

and that I last saw him alive Sept 4th 1948

Immediate cause of death — DURATION

Due to: Heart wound — Instant

Due to: Pistol Shot.

Other conditions: Abdominal & Lung wounds

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy (Yes or No)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of

Where did injury occur? near Bishopsville (City or town) Worcester (County) Md (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Pistol Ruralized at work? No

23. SIGNATURE: R E Carlton Jr M.D. M. D. or other

Address: Pocomoke City Md. Date signed 9/5/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09800

1950

CERTIFICATE OF DEATH

Reg. Dist. No. 351

WITHIN CITY LIMITS

1. PLACE OF DEATH: County Worcester; City or town Snow Hill (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo 28 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Worcester

City or town Snow Hill (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Johnnie Lee Nelson

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4 - 1948

8. AGE: Years 0 Months 6 Days 28 If less than one day hrs. min.

9. Birthplace Snow Hill Worcester, Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Riley J. Nelson

13. Birthplace Georgia

MOTHER 14. Maiden name Ella M. Wright

15. Birthplace Maryland

16. Informant Ella M. Nelson

Address Snow Hill, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 2/48 (month) (day) (year)

Cemetery or crematory Baptist

Location Snow Hill Md

18. Funeral director Lelar E. Dennis

Address Snow Hill, Md

19. 9-7 1948 (Date rec'd by registrar) Reday Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1948, at 1:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/31/48 1948 to 9/2/48 1948 and that I last saw him alive on Sept 1 1948

Immediate cause of death Asphyxia from aspiration of vomitus — DURATION 1 day

Due to Gastro-enteritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Cohen M.D. M. D. or other

Address Snow Hill Md Date signed 9/2/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. Incorrect or illegible entries delay issuance of permit. Physicians: please write the causes of death clearly and legibly. Information is especially important.

VS A15 9-45-15M

09801

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1318

Reg. Dist. No. 355

1. PLACE OF DEATH:
County Worcester
City or town Berlin Md R1D
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Worcester
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charlotte Ann Powell.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife John J. Powell.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 15, 1870

8. AGE: Years 78 | Months 2 | Days 12 | If less than one day ..... hrs. ..... min.

9. Birthplace Berlin Wor Co. Md.
(Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business

FATHER 12. Name Wesley Gaulb.
13. Birthplace Maryland

MOTHER 14. Maiden name Sally Mary Baker
15. Birthplace Maryland.

16. Informant Miss Mary Warren
Address Berlin Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/30/48 (month) (day) (year)
Cemetery or crematory Odd Fellows.
Location Bishopville Md.

18. Funeral director Dennis A Bunting
Address Berlin Md

19. 9-30- 1948 (Date rec'd by registrar) Helen L. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1948 at 10.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19..
and that I last saw h.. alive on Sept 25 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Arteriosclerosis	
Due to	
Other conditions Chr. Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Chas R. Lowe MD
M. D. or other
Address Berlin Md Date signed 9-28-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 09802

Reg. Dist. No. 353

1. PLACE OF DEATH:

County: Worcester

City or town: Ocean City - Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Worcester

City or town: W. Ocean City

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R. D. Berlin, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Julia E. Powell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife: Isaac Powell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 26 1850

8. AGE: Years: 98 Months: 8 Days: 2 If less than one day: hrs. min.

9. Birthplace: del. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

MOTHER FATHER

12. Name: James Treasure

13. Birthplace: Del

14. Maiden name: Elizabeth Rogers

15. Birthplace: Del

16. Informant: Mrs. Elizabeth McDougall

Address: Berlin, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 30 1948 (month) (day) (year)

Cemetery or crematory: Bethel Cemetery

Location: Ocean City, Del

18. Funeral director: Henry H. Watsons

Address: Pocomoke, Md.

19. Sept 29 1948 (Date rec'd by registrar) Hilda R Burgy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 28 1948, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1948 to Sept 1948 and that I last saw her alive on Sept 28 1948.

	? DURATION
Immediate cause of death: Respiratory failure	
Due to: Congestive heart failure.	4 mos.
Due to: Arterio-sclerotic cardio-vascular disease.	years.
Other conditions: Advanced age.	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: D. Townsend Jr. M.D. M. D. or other

Address: Ocean City, Md. Date signed: Sept 29, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

830 09803

Reg. Diat. No. 355

1. PLACE OF DEATH:

County: Worcester.

City or town: Bishops Showell.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Worcester.

City or town: Showell
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Margaret Taylor Dunlea.

3. (b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	White	married.

6.(b) Name of husband or wife: Thomas J. Dunlea

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Sept. 15, 1877

8. AGE:

Years	Months	Days	If less than one day
77	09	12	hrs. ... min.

9. Birthplace: Newark Wor Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business

FATHER
12. Name: Joseph Henry Taylor
13. Birthplace: Md.

MOTHER
14. Maiden name: Cordelia Harmon
15. Birthplace: Md.

16. Informant: Mrs. Thomas J. Dunlea.
Address: Bishops Md.

17. (Burial, cremation, or removal. Which?) burial Date thereof: 10/3/48 (month) (day) (year)

Cemetery or crematory: Evergreen.

Location: Berlin Md.

18. Funeral director: Anne A. Burbage

Address: Berlin Md.

19. 10-2-1948 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 30 1948, at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw her alive on Sept 29 1948

Immediate cause of death	DURATION
Due to: Cerebral Hemorrhage.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: Chas. R. Lear M.D. (M. D., or other)

Address: Berlin Md. Date signed: 9-30-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

098114

932

Reg. Dist. No. 350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Worcester
City or town Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 39 years
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Pocomoke Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 601 Fourth Street
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Daniel W. Shaw Sr.

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Lovie A. Shaw
6.(c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) May 22 - 1867

8. AGE: Years	Months	Days	If less than one day
81	4	5	...hrs. ...min.

9. Birthplace Philadelphia Penna.
(Town, county, and state)
10. Usual occupation Barber
11. Industry or business —

FATHER
12. Name D. W. Shaw Sr
13. Birthplace Penna

MOTHER
14. Maiden name Mary W. Shayman
15. Birthplace Maryland

16. Informant D. W. Shaw Jr.
Address Pocomoke City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 29 1948 (month) (day) (year)
Cemetery or crematory Presbyterian Cemetery
Location Pocomoke City Md.

18. Funeral director Henry S. Polk
Address Pocomoke Md

19. Sept 29 1948 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1948, at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 26 1948 to Sept 27 1948 and that I last saw him alive on Sept 27 1948

Immediate cause of death	DURATION
Cerebral Embolus	1 hr.
Due to Hypertensive Cardio-Vasc. Disease	Years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Louis L. Llewellyn M.D.
M. D. or other
Address Pocomoke City Date signed 9/27/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09805

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 855

1. PLACE OF DEATH:

County Worcester

City or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Worcester

City or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Daniel Henry Shockley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower.

6.(b) Name of husband or wife Emma Scott Shockley

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1863

8. AGE: Years 85 | Months 5 | Days 22 | If less than one day ... hrs. ... min.

9. Birthplace Powellville Worcs Co Md. (Town, county, and state)

10. Usual occupation Retired Farmer.

11. Industry or business

FATHER 12. Name Daniel H. Shockley Sr

13. Birthplace Maryland.

MOTHER 14. Maiden name Ellen Dennis.

15. Birthplace Maryland.

16. Informant Mrs. Ivlen Shockley

Address Berlin Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/1/48 (month) (day) (year)

Cemetery or crematory Evergreen.

Location Berlin Md

18. Funeral director Dana A. Burbage

Address Berlin Md

19. 10-1- 1948 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1948 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute Dilated Heart	
Due to	
Due to	
Other conditions Chr. Nephrosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. R. Lee M.D. M. D. or other

Address Box 38 Berlin Date signed 9-30-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09806

106 D

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:
County: WORCESTER
City or town: RURAL - TAYLORSVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 MOS.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: DELAWARE County: NEW CASTLE
City or town: WILMINGTON
(If outside city or town limits, write RURAL and give nearest town)
Street No. 600 S. VANBUREN ST.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JAN TOMCZYK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife: ALEXANDRA
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): DEC. 22, 1880

8. AGE: Years	Months	Days	If less than one day
67			hrs. min.

9. Birthplace: POLAND (Town, county, and state)
10. Usual occupation: RETIRED LABORER
11. Industry or business: SHIPYARD - PUSEY & JONES CORP.
FATHER — 12. Name: NO RECORD
13. Birthplace:
MOTHER — 14. Maiden name: NO RECORD
15. Birthplace:
16. Informant: MRS. HELEN LYNCH
Address: TAYLORSVILLE MD.
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 9/10/48 (month) (day) (year)
Cemetery or crematory: CATHEDRAL CEM.
Location: WILMINGTON DEL
18. Funeral director: EDWARD FENNOWS
Address: MILLINGTON MD.
19. 9-9- 19 48 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 Sept 19 48, at 4 6 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 48, to 7 Sept 19 48
and that I last saw h IM alive on 6 Sept 19 48

	DURATION
Immediate cause of death: Hypostatic Pneumonia	
Due to: Emphysema & Cor pulmonale	5 yrs.
Due to: Bronchitis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Fernando Radcliffe M. D. or other
Address: 5 Bay St. Berlin, Md. Date signed: 8 Sept 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

09807

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

-92-

Reg. Dist. No. 350

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 408 Market St,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 408 Market St,
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Margaret J. Townsend

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: *** John F. Townsend
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 15. 1877

8. AGE: Years	Months	Days	If less than one day
71	2	22	..... hrs. ..... min.

9. Birthplace: Somerset County, Maryland (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business

FATHER
12. Name: William Elliott
13. Birthplace: Somerset County, Maryland

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Mrs Myrtle A. Ennis
Address: Pocomoke City, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/10/1948 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Eastern Ave, Baltimore, Maryland

18. Funeral director: Howard A. Gill
Address: Pocomoke City. Maryland.

19. Sept. 9 1948 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept, 6. 1948, at 11 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 19.. to Sept. 6 1948
and that I last saw her alive on Sept 6, 1948
Immediate cause of death: Cerebral Thrombosis
Due to: Hemiplegia
Due to: Mitral Stenosis.
Due to: Hypertension
Other conditions

DURATION
20 Yrs.

? (Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Louis L. Llewelyn, M.D. M. D. or other
Address: Pocomoke City Date signed 9/9/48

09808

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

830

Reg. Dist. No. 350

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: ~~Worcester~~
City or town: Rural Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Henry West

3.(b) Social Security Number: 170-12-2225

4. Sex: M
5. Color or race: Col
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or ~~wife~~: Maggie Rogers West May 8, 1883
6.(c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): D. K. 1882
8. AGE: Years: 64 Months: Days: If less than one day ... hrs. ... min.
9. Birthplace: Accomack Co. Va. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Saw mill
FATHER 12. Name: Don't Know
13. Birthplace:
MOTHER 14. Maiden name: Rose Bailey
15. Birthplace: Accomack Co. Va.
16. Informant: Beatrice B. Poulson
Address: Melfa Va
17. Burial (Burial, cremation, or removal, Which?) Date thereof: September 16, 1948 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Shiloh, Boston Virginia
18. Funeral director: Alfred U. Ames
Address: Melfa Virginia
19. Sept 15 1948 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 13 1948, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1948, to Sept 13 1948
and that I last saw h~~im~~ alive on Sept 13 1948

Immediate cause of death: Apoplexy — DURATION: 5 days
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: [illegible] Date signed: 9-14-48

VS A15 9-45-15M